Statement of Arl Van Moore, Jr., M.D., FACR
Chair, Board of Chancellors, American College of Radiology
To the
House Energy and Commerce Health Subcommittee
Use of Imaging Services: Providing Appropriate Care for Medicare Beneficiaries

July 18, 2006

Chairman Deal and Distinguished Members of the Subcommittee,

My name is Arl Van Moore, Jr., M.D. and I am the Chair of the Board of Chancellors for the American College of Radiology. I am a practicing radiologist from Charlotte, North Carolina. It is a pleasure and an honor to represent the more than 32,000 members of the American College of Radiology before this distinguished body.

The College is the nation's largest radiology specialty organization representing diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists. Our goal remains to advance evidence-based criteria to support the delivery of higher quality, safe, appropriate and cost-effective diagnostic imaging services. Today, I will be discussing the imaging provisions contained in the Deficit Reduction Act of 2005 (DRA), their impact on providing imaging services to Medicare beneficiaries and the College's recommendations for addressing the rapid growth in utilization of imaging services in Medicare through the establishment of quality and safety standards.

I would like to thank Chairman Deal and the Members of the Subcommittee for holding this hearing and recognizing the important role medical imaging plays in the quality of care provided to Medicare beneficiaries. I especially want to thank those Members of the subcommittee who are already cosponsors of HR 5704, the Access to Medicare Imaging Act of 2006, introduced by Congressman Pitts. This legislation calls for a 2-year delay in the implementation of the DRA imaging provisions in order to allow for a GAO study to examine the potential effects on Medicare beneficiary access to the latest medical imaging technology and procedures. I believe these cosponsors' participation underscores the importance of this issue and would encourage other Members of the subcommittee and full committee to become cosponsors.

Furthermore, I would like to state that the ACR is proud to be a founding member of the **Access to Medical Imaging Coalition (AMIC),** a broad alliance of patient advocacy groups, medical manufacturers, and providers. As one of several AMIC members testifying today, ACR fully supports the enactment of 5704.

DRA Concerns

The ACR continues to encourage and support the technological innovations and advances in diagnostic medical imaging, which have unequivocally improved the quality of patient care while producing cost savings through less invasive diagnostic techniques. As medical physicians

who have devoted over 75 years to the study, and practice of the science and clinical application behind imaging technologies, the ACR and its members' training, expertise and passion is focused on medical imaging. As a result, we have serious concerns regarding the affects that the severe reimbursement cuts contained in section 5102(b) of the DRA will have on the provision of imaging services to our Medicare patients.

ACR fully understands Congress' need to make difficult budgetary decisions to maintain the solvency of the Medicare trust funds and we have always been willing to work with Congress to develop reasonable policies to accomplish this mutual goal. However, the College has some serious concerns with the policy contained in section 5102(b) which arbitrarily applies the hospital outpatient payment system and does little to neither address the issue of utilization nor improve the quality of the care provided to Medicare beneficiaries. Some examples of imaging procedures and the severity of their cuts include:

- CT angiography to examine heart arteries - reduced by 50 percent;
- PET/CT exams to pinpoint tumor location - reduced by 50 percent;
- MRI of the brain which is used primarily to diagnose brain tumors - reduced by 50 percent;
- MRI of the abdomen which is used to diagnose abdominal and/or liver cancer - reduced by 48 percent; and
- MR angiography of the head which is used to detect the location of aneurysms - reduced by 42 percent.

The College finds it hard to believe that the Congress and Members of this subcommittee were aware that this policy would result in such dramatic cuts in the payment of such vitally important medical imaging procedures. In addition, reimbursement policies that pick and choose between payment systems based primarily on the budget savings available to be achieved without validating the accuracy of either system or examining the applicability of either system corrupts and invalidates both payment systems.

ACR's concerns with the DRA imaging provisions fall into two basic categories; the policy setting process of the Conference Committee of the DRA and the actual imaging reduction policy that was enacted. When a provision is offered to the Conferees which results in a $2.8 billion direct reduction in physician fees, one would hope that such a provision would be debated in committee, on the House or Senate floor or be the subject of a study by an outside federal agency as to the effects of such a policy. Regrettably, none of this oversight occurred with regard to section 5102(b). We think the results of this inaction during conference resulted in a policy that subjects and singles out a particular range of physician services to severe reimbursement reductions that are unfounded, and fails to address, in any way whatsoever, concerns Members of Congress may have about the appropriate and safe use of complex imaging tests on our Medicare beneficiaries.

We understand the philosophy behind the intent of the Congress to pay equally for the same imaging service, regardless of the site of its delivery. However, the policy included in the DRA arbitrarily replaces the long established and validated Medicare Physician Fee Schedule payment system, with the non-validated Hospital Outpatient Prospective Payment System (HOPPS) for the Technical Component reimbursement.

The Balanced Budget Act of 1997 (P.L. No. 105-33) called for the Secretary of HHS to develop the HOPPS methodology for hospital outpatient services. Outpatient services typically are performed at a hospital and include routine visits, emergency room visits, diagnostic medical imaging services, and surgical procedures not performed as part of an inpatient stay. The hospital outpatient payment system was never designed to accurately reimburse physician practice expense outside of the hospital setting and its applicability to the cost structure of non-hospital sites of service, such as a physician office or an imaging center, has never been examined. Moreover, HOPPS fails to adequately account for the capital-intensive nature of diagnostic medical imaging services provided for in an office setting, where there is often less volume of services.

Unlike the Resource Based Relative Value System (RBRVS), which a prior Congress required to be based on specific procedure level resource costs in determination of reimbursement, the HOPPS was never intended to accurately reflect resource costs at the procedure level. The HOPPS classification methodology is a hospital case mixed index not intended to be a procedure level payment. This new Congressional proposed reimbursement scheme effectively removes physician input and the resource basis from the reimbursement system and negates the careful and rigorous work performed by the AMA Practice Expense Advisory Committee (PEAC) over the past six years.

The convoluted methodology of the HOPPS, which has relatively minor physician input into the process, is ultimately based on what hospitals report as their 'costs' for the various outpatient procedures. This reporting system is notoriously inaccurate and is not systematically validated. Before Congress discards the MPFS methodology in favor of the HOPPS methodology it should be sure that the hospitals are showing all of their costs for outpatient imaging services, especially CT and MRI as some of these costs may be allocated to the Part A Medicare payments (DRGs). Rather than blindly believing that the MPFS over reimburses CT and MRI procedures performed in an office setting, you should have considered the more likely probability that hospitals are not showing all of their costs and, as such, that hospitals are under reimbursed.

For example, much of the cost of providing these state of the art imaging services is in the cost of the equipment. The HOPPS methodology has no specific mechanism for capturing those costs and it is quite possible that hospitals are not reflecting equipment purchase costs in their reporting system. Implementation of the legislation transitioning the HOPPS payments to the Medicare Physician Fee Schedule ***must be delayed*** until this answer is known. Otherwise, Congress may unwittingly put many imaging centers out of business because it never bothered to understand that the new reimbursement level may not even cover the costs of providing many imaging services. Simply stated, the HOPPS system was never designed to account for the costs of in-office imaging and therefore cannot be expected to be an accurate measure of the costs associated with in-office imaging.

Furthermore, the imaging cuts in the bill represent nearly a third of overall reductions in the Medicare program that were contained in the DRA and do not address the utilization concerns of many in Congress. When taken in tandem with ongoing CMS rulemaking reductions such as CMS's November 2005 final rule on contiguous body parts and CMS's June 2006 proposed rule that discusses the 5 year review and revisions to the practice expense methodology, the combination of these policies cross the threshold of defensible public policy and become arbitrary and punitive reimbursement reductions. If these cuts are implemented in January 2007, many physicians may be forced to stop offering much needed imaging services or limit the

number of Medicare patients they receive. It is possible that many rural areas of the country will be affected. As a result, Medicare beneficiaries may be forced to endure increased wait and travel times to receive imaging services and higher co-payments for certain studies performed in the outpatient setting.

Many ACR members, in response to this policy, have expressed their concerns that in the event these payment reductions go into effect that they will likely be forced to reduce their hours significantly, cut staff or close altogether since they cannot increase their volume by performing more examinations in order to offset these losses. In addition to the access problems that will inevitably occur, ACR is also concerned that these cuts may discourage research and development of new imaging technologies that are increasingly replacing more invasive (and more costly) techniques. I'm sure the NEMA representative testifying today can verify that many of our members are stopping orders for new equipment and/or updates for older equipment.

Alternative Policies

Mr. Chairman, we recognize that of section 5102(b) of the DRA is intended to reduce the growth and the costs of medical imaging in Medicare. However, the DRA policy does nothing to address the growth in imaging services. Therefore, ACR and our colleagues in our Coalition, believe this issue requires a more thorough analysis, and not the sledge hammer reimbursement cuts enacted early this year. The two year moratorium contained in HR 5704 should give Congress ample time to accomplish a more thoughtful analysis of the potential unintended consequences that such severe payment cuts could portend.

To address the growing concern of policy makers in the public sector as well as with private payers who have worried about the tremendous growth in usage of PET scans, CT and MRI tests, the College has advocated for the last two years that utilization can be controlled through the development of quality and safety standards. We believe that Medicare should only pay for those complex imaging tests, CT, MRI and PET, if they are performed in a safe and controlled environment. We believe that any physician, regardless of their specialty, should meet minimum quality and training standards. We think the equipment must continue to be of the highest caliber, with continuous maintenance to monitor the numerous safety issues associated with these complex tests. Some may view this position as anti-competitive on the part of radiologists, but we view the requirement of quality and safety standards as providing the necessary assurance to patients and taxpayers alike, that these services are being carried out in the most appropriate manner. The complexity, cost, and possible radiation exposure often associated with many of these procedures require and demand special consideration of federal quality standards.

The Mammography Quality Standards Act (MQSA)

The requirement of federal quality standards already *has* governmental precedent. In 1992, Congress enacted the Mammography Quality Standards Act or MQSA. This congressionally established program sought to increase the quality of mammographic images by setting standards for the facility, technicians and physicians involved in the mammography process, thus improving breast cancer diagnosis and ultimately breast cancer survival. Since the establishment of MQSA, earlier detection of breast cancer through quality imaging has saved thousands of women's lives.

ACR believes that if Congress thought it was important to ensure quality for the x-ray procedures involved in mammography, then it is logical that Congress would want to enact similar standards for other imaging procedures that are more complex, such as CT, in which the radiation dose is 200 times that of a conventional chest film. Clearly the Centers for Medicare and Medicaid Services (CMS) has begun to move in this direction as evidenced by its October 1, 2004 transmittal number 24 which incorporated into Medicare regulation a national coverage determination for PET scans that includes facility accreditation and demonstrated physician interpreter expertise as a requirement of coverage. Specifically, the CMS languages states "The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia."

While MQSA is not perfect, physicians have accepted these standards. Advances in technology continue, including recent findings that the latest digital mammography may be a particularly effective test for some high risk groups of women. Most importantly, the level of care has greatly improved and our patients, your constituents, have benefited from early detection, increased survival rates and reduced death rates.

Medicare Payment Advisory Commission (MedPAC) Recommendations

In its June 2004 and March 2005 reports to Congress, MedPAC's recommendations, which are not specialty specific, call for all diagnostic imaging providers to meet quality standards for imaging equipment, non-physician staff, images produced, patient safety protocols, and increased training for physicians who bill Medicare for interpreting diagnostic imaging procedures. As suggested by MedPAC in its March 2005 report, these standards would be determined by the Secretary of Health and Human Services (HHS) in consultation with physician specialty associations and nationally recognized accreditation organizations. Therefore, those physicians that are committed to obtaining the training, education, personnel and equipment necessary to meet these standards will continue to be able to provide services to their patients. The ACR urges the subcommittee to seriously consider and follow the advice of its advisory commission.

According to data compiled for the ACR, Congressional implementation of the MedPAC recommendations, designed in part to stem the financial incentive associated with some of the growth in imaging utilization, could save the Medicare program a minimum of $4-6 billion over ten years (the analysis behind this cost savings has been previously provided to Committee staff). Given the likelihood that Medicare spending on the highest-cost modalities may approach $100 billion over the next ten years, deterring just 5 percent of projected spending would represent a substantial savings to Medicare. We believe that if quality of care standards were adopted, Medicare beneficiaries would receive fewer duplicative studies, with more accurate and better image quality of the range of tests available.

Independent Diagnostic Testing Facilities

While much of the increase in imaging procedures is due to the growing value of imaging as an alternative to more invasive diagnostic techniques, there is continued concern about the proliferation of expensive imaging equipment outside the traditional setting of the hospital or

radiology group practice. It is in these non traditional settings where uniform quality and safety standards, usually associated with hospital and radiology group practices, do not exist.

The ACR feels that CMS currently has the authority to assert quality and safety standards to all settings where complex imaging testing is done if CMS were to expand their current Independent Diagnostic Testing Facility (IDTF) program to all settings where these tests are performed. Currently each state has authority to regulate how diagnostic imaging services are performed if such services are performed in an IDTF. Some states are diligent in this overview while others are more lax.

In order to make these standards uniform for all states, the ACR feels that CMS should nationalize the IDTF standards, and insist that the provision of CT, PET or MRI exams, when performed in an office setting should meet the qualifications of, and register as an IDTF. CMS has this authority to expand the existing IDTF program and the ACR urges the Congress to seriously consider this avenue of policy making as a fairly direct way to address many of the concerns raised in this hearing.

Private Insurers

Today, third party payers across the country are looking for ways to reign in imaging costs while ensuring that there is no negative impact on the quality of patient care. To improve image quality and reduce costs, some insurers are following accreditation models similar to those proposed by MedPAC and ACR.

More and more payers recognize that accreditation programs are a key element in evaluating and maintaining the quality and safety of imaging for their patients. In recent years carriers in various markets across the country have mandated accreditation in complex imaging modalities such as MRI and CT for their providers. Until now the only national mandate was for MRI accreditation that was implemented in 2001 by Aetna. Recently, another national payer has indicated that they will require accreditation for all providers of MRI, CT, PET, Nuclear medicine, Nuclear Cardiology and Echocardiography beginning in late 2007.

A list of some insurers and states utilizing ACR Accreditation is attached to this testimony and include Aetna, Blue Cross of California, Highmark Blue Cross of Pennsylvania, Blue Cross Blue Shield of Alabama, United Health Group of Wisconsin, Cigna of Connecticut and Oxford to name a few.

Conclusion

The ACR represents those physicians who focus solely on medical imaging and have unrivaled expertise in radiological sciences, medical imaging techniques, radiation safety, radiation protection, dose delivery and image interpretation programs. We are committed to evidence based decision making in healthcare and dedicated to high quality, safe and effective patient care through all of its available resources.

I would like to reiterate my appreciation for your interest and concern that Medicare beneficiaries continue to receive the life-saving technology found in diagnostic imaging services. We hope the subcommittee, as well as the entire Congress, will work to enact the provisions

contained in HR 5704 so that we can implement an effective and sensible imaging reimbursement policy that will benefit our patients and the health care system overall.

I look forward to any questions you may have.

Thank you.